DOCUMENT RESUME

ED 275 935 CG 019 467

AUTHOR Wenar, Charles
TITLE Childhood Depression Viewed as Normal Development Gone Awry.
PUB DATE [Aug 86]
NOTE 10p.; Paper presented at the Annual Convention of the American Psychological Association (94th, Washington, DC, August 22-26, 1986). Charts contain small type.
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Child Development; *Children; *Depression (Psychology); *Developmental Psychology; Emotional Response; *Psychopathology; *Self Esteem
IDENTIFIERS *Loss

ABSTRACT

Childhood psychopathology can be viewed as normal development gone awry. The key to the mysteries of masked depression and of depression in the infant/toddler period and in middle childhood lies in the concept of loss. Children who experience the loss of a loved parent or caretaker through that person's death may evidence a variety of behaviors (anger, acting-out, anxiety, denial) which can be interpreted as masked depression. Depression can also be caused by a loss of self-esteem. Loss of a caretaker and loss of self-esteem may be similar in some respects, but are different in their origins. Loss of a loved caretaker appears fully formed in early development. Loss of self-esteem develops over time and is heavily influenced by experience and learning. The general conclusion from research on self-esteem loss is that depression is not possible in the preschool period but becomes possible in middle childhood. Studies of self-esteem, however, assume a normal child in a growth-producing environment while clinical data concern vulnerable children in deviant environments. Therefore, at a practical level, clinicians should not uncritically accept the conclusion that depression is impossible in the preschool years. If one considers psychopathology to be normal development gone awry, one must trace psychopathology back to its origins in normal development and attempt to understand what happens to normal development to divert it from its course. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED275935

Childhood Depression Viewed as Normal Development Gone Awry

Charles Wenar

The Ohio State University

I. Introduction.

Developmental psychopathology is an increasingly popular term which means different things to different people. To me it means that all childhood psychopathology can be viewed as normal development gone awry. Among other things, this means that it makes no sense to single out autism or dyslexia as developmental disorders (as is done in DSM-III) while regarding phobias or enuresis as non-developmental.

The basic assumption is that all development is one. Whether an individual chooses to study normal or deviant populations is a matter of personal interest.

Another basic assumption is that the constant exchange of ideas and data between those studying normal and deviant populations will enhance our understanding of development in general.

II. Depression and Loss.

I would like to illustrate the above thesis by applying it to child depression and to two specific mysteries: the mystery of masked depression and the mystery of the two depressions, one in the infant/toddler period and one in middle childhood.

The key to both mysteries lies in the concept of loss but two different kinds of loss: loss of a loved caretaker and loss of self love.

III. The Mystery of Masked Depression.

CG 019467

Until recently, it was believed that children in middle childhood were incapable of becoming depressed at the death of a loved parent but, instead, evidenced a variety of behaviors which were interpreted as masking depression. When it was discovered that such children can and do become depressed, masked depression itself vanished! I suspect this was a mistake and that the original clinical observations were valid. This suggests that the reaction to death is a mixed one which includes depression but also anger and a variety of acting out behaviors, and, to a lesser extent, anxiety and denial. In fact, recent research suggests that a high correlation between depression and aggression distinguishes childhood depression from its adult counterpart.

The next step is to scan normal development for a similar constellation of reactions to loss. The most obvious example is Spitz's classical description of anaclitic depression as elaborated and conceptualized by Bowlby in terms of attachment theory.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Charles Wenar

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

To review Bowlby's conceptualization briefly:

First stage - Protest which consists of:
an anguished yearning for the caretaker's return
an angry striking out at substitute caretakers
agitation as attachment behaviors are aroused but cannot be consummated

Second stage - Despair or abandoning hope for reunion

Third stage - Denial or the defense against the pain of loss

Now, if one combines Bowlby's data with that on masked depression one sees both how nicely they complement one another and how readily they conform to developmental trends and principles.

(See table on Loss of Loved Caretaker. Ignore checkmarks which were aids to the audience. See also, Developmental Trends and Principles. The checked items typically refer to the table on Loss of Loved Caretaker.)

IV. The Loss of Self Worth.

Depression can also be caused by a loss of feelings of self worth due for example, to critical parents or school failure or unpopularity. This second kind of depression has been epitomized by the triad of feelings of worthlessness, helplessness and hopelessness.

Again, let us put these clinical findings into the context of normal development by turning to the research on self worth or, as it is more typically called, self esteem.

Self esteem has been studied by both academic psychologists and psychoanalysts who, independently, arrived at similar conclusions. (Incidentally, in spite of everything you have read, Freud did not believe that all depression is due to hostility turned inward. This was his formulation for psychotic depression only. He recognized that depression could also be due to a narcissistic blow to the ego, or what we are calling a feeling of worthlessness.)

Self esteem is conceptualized as having 5 sources - competence, power, moral worth, loveworthiness or respectworthiness and an overall feeling. These, in turn, are due to different combinations of self evaluations and the evaluation of significant other - parents, teachers and peers.

(See table on Self Esteem. Ignore stars which were aids to the audience.)

The next question is not, At what point do the processes responsible for self esteem enter the developmental picture? but, At what point do they become sufficiently potent and stable so that loss of self esteem would lead to depression? This evidence is summarized in Table B on Underlying Processes. (Again, ignore stars. For the Developmental Trends and Principles, see starred items.)

The general conclusion from these data is that depression is not possible in the preschool period but becomes increasingly so in middle childhood.

V. Comparison of the Two Kinds of Loss.

On the response side, the two kinds of loss may be similar, although more needs to be known about the complex of behaviors resulting from loss of self esteem.

However, the two are quite different in regard to origins:

Loss of a loved caretaker is one of those patterns which appears fully formed in early development. It seems to be "wired in" and does not depend on experience and learning.

Loss of self esteem, by contrast, develops over considerable periods of time and is heavily influenced by experience and learning. Instead of appearing in its totality, its different sources have different timetables, feelings of being unloved, for example, entering earlier than feelings of being incompetent at school.

VI. Critique.

While the findings on self esteem are fascinating and illuminating, they may be too purely cognitive and too narrowly cognitive to be applied uncritically to clinical data.

They are too purely cognitive for two reasons: they neglect affect and the issue of centrality. The latter is particularly unfortunate. Not all sources of self esteem are equally potent: a straight A student may be devastated by a B and seriously consider suicide while his roommate is relatively unaffected by grades. Clinicians cannot ignore centrality because it is those sources of self esteem containing gut values which determine whether a child will become psychopathologically disturbed.

Clinicians may be surprised to see that guilt does not become an important determiner of behavior until adolescence. This does not correspond to clinical experience and suggests guilt may have been too narrowly defined. It is not unusual for physically or sexually abused 6- to 9-year-olds, for example, to be tortured by the question, "What did I do wrong that this happened to me?" Incidentally, this is an illustration of Piaget's concept of moral realism: Because parents did something bad to me I ipso facto must have been bad.

VII. Two Basic Issues.

A basic problem is that studies of self esteem assume a normal child in a growth promoting environment. Clinical data, by contrast, concern vulnerable children in deviant environments. This difference has two implications.

At a practical level, it means that clinicians should not uncritically accept the conclusion that depression is impossible in the preschool years. It may be that a vulnerable child who is constantly being called Bad, Stupid, and No Good by caretakers will adopt their evaluation and become depressed. At least, the possibility should be kept in mind. Having recently made the mistake of assuming that depression was impossible in middle childhood because of superego development, psychologists should be wary of making a similar mistake about the preschool period because of cognitive development.

More generally, clinical data represent experiments in nature showing what happens to development under extreme circumstances. It is as if the clinician were asking: What happens to development if the brain is damaged rather than intact, or if parents are brutal instead of loving, or if infants cannot form an attachment or imitate or explore with confidence? In the present case, clinicians can put the findings on normal development to the test: Can they be generalized to deviant children? If so, well and good. If not, what changes must be made in our concept of the development of cognition and affect in order to accommodate the discrepant data?

In either case, the exchange of data and ideas between investigators of normal and deviant children advances our understanding of development itself.

Which means I am back where I started, and so it is time for me to stop.

Note: If one believes that psychopathology is normal development gone awry, then one has two challenges: first, to trace psychopathology back to its origins in normal development, as was done here, and second, to understand what happens to normal development to divert it from its course; e.g., why does normal protest and despair become depression, or why do the forces responsible for self esteem produce despair instead? Time did not permit a presentation of this issue, although very little is known concerning it.

LOSS OF LOVED CARETAKER

	I. Response to Lost Caretaker					II. Response to Other Caretakers		III. Externalizing Reactions		IV. Internalizing Reactions		V. Regression
	1. Painful Response	2. Longing	3. Defense	4. Solace	5. Despair	1. Dependency	2. Fear of loss	1. Restless	2. Anger	1. Intro-punitive	2. Self Concern	
Infancy	Anguished crying	Repeating caretaker's behavior	Denial	Thumb sucking Cuddling toys	Grief Apathy	Clinging	Separation anxiety	Agitation	Indiscriminate tantrums			Desire to be nursed
Toddler/ Preschooler	Crying but decreasing	Playing out longing Reminiscing	Refusal to talk of death	Masturbation	Sad Withdrawn		Separation anxiety	Agitation	Playing out anger Tantrums but decreasing		Fears own death, injury, etc.	Finger sucking Cuddling toys
Middle Childhood	Crying but decreasing		Refusal to talk of death Self-sufficiency		Sad		School phobias	Restless School work declines Gaity	Disobedient Cheating Truancy Delinquency	Worthless Hopeless Suicidal ideas	Helpless Preoccupied with death, illness	Tantrums Clinging Baby talk
Adolescence	Tearful				Dysphoric mood Listless		School phobias	Restless School work declines	Rebellious Fights Rude Drug abuse Drinks Runaway Sexual acting out	Worthless Hopeless Guilty Inferior Unloved Suicidal ideas and attempts	Helpless Fear of death, going crazy	Enuresis Incontinence

BEST COPY AVAILABLE

SELF ESTEEM

A. Middle Childhood - Description

Components	I. Competences: Cognitive	Social	Physical	II. Control (power): Cognitive	Social	Physical	III. Moral Worth: Home	School	IV. Social Loss: Family, Peers, etc.	V. Overall
Affects +	Pride									Pride, hope, confidence, vanity
-	Anxiety, self anger, inadequacy			Frustration, depression			Shame, guilt, "badness"		Loneliness, emptiness	Inferiority, shame guilt, resentment, pain
Basis for Evaluation	Speed, effort, authority's evaluation	Peers, personal attributes	Peers, ability, likes, authority's evaluation							Parental relations, anger control, self acceptance, socially appropriate behavior

B. Preschool (tentative)

Components	I. General Competence (Cognitive & Physical undifferentiated)	IV. Worthiness (Mother & peers undifferentiated)	V. No Overall
Basis for Evaluation	Practice, learning		

B. Underlying Processes

	PRESCHOOL	MIDDLE CHILDHOOD	ADOLESCENCE
I. SELF CONCEPT ("I am")	Physical self: actions body possessions	Psychological self: traits, characteristics	Adult form: integration of components stable characteristics time perspective
II. SELF EVALUATION: Worthwhile or Worthless	Absolute "Good" or "Bad" Inconsistent, inaccurate Vascillates with context Knows others are proud or ashamed of him/her	Evaluations based on: competences and abilities comparisons with others Stable evaluations possible based on: evaluations of others self evaluations Negative self evaluations & ideas of worthlessness Feels proud or ashamed of self	Adult stability achieved
III. SELF EVALUATION: Competent or Helpless (especially cognitive competence)	Can set goals, take actions to achieve, evaluate outcome, feel satisfied or dissatisfied But no explicit self evaluation, no relating outcome to personal attributes May overestimate self, underestimate difficulty Attributes contingencies where none exist	Evaluations based on: teachers' judgments comparison with peers Realistic self evaluation Pervasive feelings of helplessness Learned helplessness possible due to: realistic contingency awareness stable negative attribution	Accurate self evaluation
IV. SELF EVALUATION: Hopeful or Hopeless	Limited grasp of time; lives primarily in present	Understanding of time increases	Past and future grasped Hopelessness possible
V. AFFECT:			
1. Cognition	In others - distinguishes affects, identifies causes In self - physicalistic identification: situation, body	Distinguishes affects in self Sadness increasingly attributed to internal factors	Accurate grasp
2. Mood	Context dependent and changeable	Sadness - increasingly prolonged and sustained	Intense, persistent dysphoric mood possible
3. Guilt	Temporary guilt over accidental as well as intentional acts	Intentionality grasped	Intense, persistent guilt possible

BEST COPY AVAILABLE

Developmental Trends and Principles

✓1. Expanding the psychological environment from parents (primary caretakers) to school to community.
   Ex. From separation anxiety to school phobias
   Ex. From anger at caretaker to disobedience at school to breaking law

✓2. Expanding psychological time from living in the here-and-now to understanding past and future
   Ex. Appearance of ability to reminisce about lost caretaker
   Ex. Appearance of ability to envision a hopeless future

✓3. Increased control and moderation of affect
   Ex. Moderation of crying, apathy, agitation, and rage in response to loss of loved one.
   Ex. From diffuse striking out to context appropriate displays of anger

4. ✱a. From environmental reactive to intraindividual (self) judgments and evaluations
   Ex. From being judged "bad" to judging self as "bad" and feeling guilty

   ✱b. From intraindividual (self) evaluations to adopting social judgments and evaluations
   Ex. From evaluating one's own competence to adopting teacher's evaluations

   ✱c. From egocentric to socially predicated evaluations
   Ex. From unrealistic "I'm the best" to judging competence in relation to others

✱5. Increasing differentiation and global integration
   Ex. Components of self esteem differentiated and global self esteem emerges
   Ex. Global evaluations of self as "good" or "bad" to differentiated evaluations

✱6. From (unstable) concrete, reality bound thinking to (stable) inferential, abstract conceptualizations.
   Ex. From identifying self with body, actions and possessions to identifying self with psychological traits

✓7. From action to symbolization
   Ex. From imitating lost caretaker's behavior to playing out feelings about caretaker to verbalizing longings

✱8. From action to reflecting upon action to explicit generalized self awareness
   Ex. From "action-self" to monitoring and judging one's own actions to explicit self characterizations such as "I am worthless"

9. Miscellaneous

   ✓a. From extrapunitive to intropunitive actions; e.g., from outer to inner directed anger, guilt, suicidal ideas.

   ✓b. From primitive to sophisticated defenses; e.g., from denial of death to a refusal to talk about it to a desire for total self sufficiency

   ✓c. From oral to genital autoeroticism; e.g., from solice thumb sucking to masturbation.

   ✓d. (?) From a need to be cared for to a need for authoritative guidance from caretakers; e.g., anger directed to substitute caretakers changes to anger toward authority symbols such as teachers, police.

BEST COPY AVAILABLE

Selected Readings

Bowlby, J. (1980). Attachment and loss: Vol. 3. Loss: Sadness and depression. New York: Basic Books.

Digdon, N., & Gotlib, I. H. (1985). Developmental considerations in the study of childhood depression. Developmental Review, 5, 162-199.

Harter, S. (1983). Developmental perspective on the self-system. In P. H. Mussen (Ed.), Handbook of child psychology. New York: Wiley.

Mendelson, M. (1975). Intrapersonal psychodynamics of depression. In F. F. Flach and S. C. Draghi (Eds.), The nature and treatment of depression. New York: Wiley.

Rutter, M., Izard, C. F., & Read, P. B. (Eds.). (1983). Depression in young people. New York: Guilford Press. (See chapters by C. F. Izard and G. M. Schwartz, D. Cicchetti and K. Schneider-Rosen, M. Kovacs, and the summary chapter by M. Rutter.)